Meaningful Use Workgroup
Draft Transcript
February 26, 2010

Presentation

Judy Sparrow – Office of the National Coordinator – Executive Director
Good afternoon, and welcome, everybody, to the meaningful use workgroup. There will be opportunity at the end of this call for the public to make comments, and I'll do a roll call now. Paul Tang?

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
Here.

Judy Sparrow – Office of the National Coordinator – Executive Director
George Hripcsak?

George Hripcsak - Dept. of Biomedical Informatics Columbia University – Chair
Here.

Judy Sparrow – Office of the National Coordinator – Executive Director
David Bates? Christine Bechtel?

Christine Bechtel - National Partnership for Women & Families – VP
I'm here.

Judy Sparrow – Office of the National Coordinator – Executive Director
Neil Calman? Art Davidson? David Lansky? Deven McGraw?

Deven McGraw - Center for Democracy & Technology – Director
Here.

Judy Sparrow – Office of the National Coordinator – Executive Director
Charlene Underwood?

Charlene Underwood - Siemens Medical - Director, Gov. & Industry Affairs
I'm here.

Judy Sparrow – Office of the National Coordinator – Executive Director
Latanya Sweeney? Micky Tripathi?

Micky Tripathi - Massachusetts eHealth Collaborative - President & CEO
Here.

Judy Sparrow – Office of the National Coordinator – Executive Director
Karen Trudel? Linda Fischetti? Anybody else on the call that I missed? Josh Seidman and I are here at ONC. I'll turn it over to Paul and George.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO

Thank you, Judy. Thank you, workgroup members, for taking the time and putting up with some of the flexibility that we've built into this time. This is our last scheduled call before turning in the letter, and so the agenda items are three. One is to go over the updated draft letter, updated by the discussion in the main committee, and I do have a couple other topics to discuss, things that we have talked about in both our workgroup and in the full committee, but did not incorporate into the letter. And the reason to bring these two up is to make sure we aren't overlooking major philosophical comments, since that was our role for CMS. And I think these could be two possible ones, so I wanted to raise those. One has to do with the threshold, and the other has to do with quality measures.

The first thing is anything else to add to the agenda? Okay. The first thing is to go over the edited version of the document, which you should have all received. And there aren't that many, but let me review the ones that we have edited. On page two, recommendation 1.0, the question from the main committee was the definition of progress notes, things like, does it include questionnaires? Does it include structured templated progress notes?

The answer to the templated progress note is yes. We weren't intending for it to be only free text because I think that was part of the question. But really it's the progress note that we all know and love. Part of it, I'm not sure has an official or definitive or precise answer, but so an example of words that would describe what we mean by progress notes in either the outpatient or the inpatient setting is what I put in the parem, and it may not due it justice, but it's a clinician authored note that documents what transpired during the patient encounter.

Now the clinician authored means that it is not just a physician, and that's to give us flexibility. Let's say nursing notes are extraordinarily important in the inpatient setting especially, and what transpired during a patient encounter does not exclude other, non-face-to-face, for example, a telephone encounter or, looking towards the future, of course, an online encounter. It's the encounter between a healthcare professional and their patient needs to be documented. That's part of the standard of care, standard of practice, and legal documentation. But we also felt it was part of the information useful in coordination of care and insuring the high quality outcome.

Comments about the parenthetical definition of progress notes.

Deven McGraw - Center for Democracy & Technology – Director
Sounds fine.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
That's Deven.

Deven McGraw - Center for Democracy & Technology – Director
Of course, I'm the lawyer, so it sounds pretty legalistic.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
Good. We got a legal signoff. George, do we have a medical person?

Deven McGraw - Center for Democracy & Technology – Director
Don't you count?

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
I said the other. George, you must be on mute.

George Hripcsak - Dept. of Biomedical Informatics Columbia University – Chair
You are right, Paul. I was on mute. I was saying yes, yes.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
Okay. That works. Any other members want to comment on that?

Micky Tripathi - Massachusetts eHealth Collaborative - President & CEO
No. It makes sense to me.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
Okay. The next comment is on page four, under recommendation six, having to do with the patient specific education. I think one of the clarifications is that, so in our recommendation, we talked about the use of the data and the EHR to suggest patient specific education. Now there are comments on, well, it's fine that the topics come up. Can you print them, etc.? Or could you even, the topics get recommended by the EHR, and could you pull out from the shelf some prepared printed material?

I think the idea we had is to use what's in the EHR to try to get patient specific information as much as possible, and one of the opposites is to print the discharge instructions for heart failure patients on every discharge summary, which some hospitals have done. So we're trying to get away from that and say, look, with a patient with these conditions or these medications, what are the instructions for that person?

One modifying sentence at the end of that pros was, we anticipate, so acknowledging that some may be printed, but suggested by the EHR through the EHR, is that we anticipate that the relevant patient education resources would be electronically linked to patient information through personal health records. I'll just stop there and let people comment.

Christine Bechtel - National Partnership for Women & Families – VP
Paul, it's Christine. I agree with you, and I think that makes sense. I'm not sure that's what the sentence says.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
I agree with you, as I read it, so if someone could help with the wordsmithing of the intent.

Christine Bechtel - National Partnership for Women & Families – VP
Yes. You don't want to do that on the call though.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
If you have something right away, that's great, or phrases that we can massage. Otherwise….

Christine Bechtel - National Partnership for Women & Families – VP
Why wouldn't we say, or what about saying, we anticipate that relevant patient education resources would be provided electronically to the patient as appropriate and per their preference. That way it could be through a PHR … portal. It could be through e-mail, or it could be printed.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
Okay. One of the things we ran into, it was the confusion about when we say per preference, it wasn't clear to people. When we say that, oftentimes we mean, well, they might want it on paper, as many may. That's what we meant, versus whether they want to – well, we also mean whether they want to receive it or not.

Christine Bechtel - National Partnership for Women & Families – VP
Right. So why don't we say we anticipate that relevant patient education resources would be electronically available to patients depending on how they prefer to receive them. Is that what you're getting at?

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
Okay. Well, yes. Our idea was they should have it available electronically if that's the way they want to receive it. Otherwise, they can, you know. Have we covered that comment?

George Hripcsak - Dept. of Biomedical Informatics Columbia University – Chair
….

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
Okay. On page five, the question we got from the floor was when it said medications entered in the EHR. Someone thought, well, that could mean that you have it electronically in the electronic … your medication database electronically in the EHR. It's not the same thing as ordering it through the EHR. So I pushed those words to ordered through the EHR to mean that it's CPOE of medications.

Christine Bechtel - National Partnership for Women & Families – VP
I think that's right.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
Does that clarify it? Okay. On page six, the recommendation nine, we're dealing with the whole CPOE done by whom. Now this can be controversial, and we still heard more feedback afterwards, but the idea was, our original idea was that we wanted the authorizing provider, in most cases that's the physician, to do the direct entry because that's how the system is going to communicate back about any feedback, whether it's additional data that may be relevant to this decision, or just alerts, or reminders, or advice. That was our original intent, and that is how CPOE systems get their most benefit.

What we heard was that, well, there are other workflow issues that can make it either in a code. It may not be timely. There are phone orders or verbal orders that are conducted for various reasons, and there is a countersignature after the fact. And, no, the physician wouldn't get the feedback, at least in current systems, when they do a countersignature. That's some of the feedback we got.

Charlene Underwood - Siemens Medical - Director, Gov. & Industry Affairs
Also just the practice in ICU with the complex medications, the pharmacist does it. I mean, they do it. The doctor is there, but they've got to calculate that stuff, and they'll have the pharmacist do it.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
Okay. So there are various reasons. Now let me read you what I wrote, and let's hear some discussions about the notion of is it, you know, how strongly to hold to the entered directly by the physician, and that also speaks to the threshold issue as well because, as you know, for outpatient, it's 80%. For inpatient, it's 10%.

So, at the same time, we recognize that in the normal practice of medicine, there are times when the authorizing provider is either not able to enter the orders directly: telephone orders, verbal orders, and emergency situations, the whole academic medical practice. And so, for that reason, the threshold percent should be set at a level that recognizes the legitimate reasons for less than 100% of the orders being entered directly. What that's saying is that we should relax the threshold as one way to accommodate the various reasons why you may not have all the orders entered in.

Feedback on that? It's a comment on thresholds. It's a comment. It relaxes whether the real intent is for virtually 100% to be ordered directly. Feedback, reactions?

Latanya Sweeney – Laboratory for International Data Privacy – Director
This is Latanya.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
Hello, Latanya.

Latanya Sweeney – Laboratory for International Data Privacy – Director
I don't have the text in front of me, but when you were reading it, I thought maybe we were looking for a different kind of angle. I read it that on relaxing the threshold specifically if the provider is not making the order, as opposed to, we want the orders electronic, and we'll allow for them not to necessarily be by the provider.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO

Our original, and this will get to the second topic, but our original request was that things be reported, but not necessarily have a threshold. Through the NPRM process, they attributed a threshold of 80% of the orders being – gosh. You know what? I'd have to get that in front of me. I think it's 80% of the orders entered in directly by the authorizing provider. And for all the reasons described, it may not even – even though you are meeting the spirit and the intent of the objective, 80%, i.e. a high threshold may be too high when you think of all the reasons why you may not want to do it that way.

Latanya Sweeney – Laboratory for International Data Privacy – Director
Right, but my question is, do we want to keep the threshold there and take away that it has to be by the provider…?

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
Yes.

Latanya Sweeney – Laboratory for International Data Privacy – Director
In other words, it could be the provider, someone on the provider's team.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
Correct, and that's the options that we're trying to discuss.

Latanya Sweeney – Laboratory for International Data Privacy – Director
Right.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
I think it's fair. I mean, do you have an opinion one way or the other?

Latanya Sweeney – Laboratory for International Data Privacy – Director
Yes. I liked it better, the provider's team, and trying to keep as much of the data being electronic as possible.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
Okay.

Latanya Sweeney – Laboratory for International Data Privacy – Director
That's my first instinct.

Deven McGraw - Center for Democracy & Technology – Director
Yes, that would be mine too. This is Deven. I felt like that discussion we … I mean, I think I understood the reason why we were trying to specify that it had to be the authorizing provider, but it just raised a whole lot of complications, and more important to get the orders in, and let them worry about who is authorized to do them or not.

George Hripcsak - Dept. of Biomedical Informatics Columbia University – Chair
…suggestion is, we should just get rid of the recommendation, right?

Deven McGraw - Center for Democracy & Technology – Director
Yes, I may be suggesting that. Maybe I should ask, as a threshold matter, remind me of the reason why we thought it was so critical that we designate who it is that does CPOE.

George Hripcsak - Dept. of Biomedical Informatics Columbia University – Chair
We were afraid that we would create new workflows through meaningful use to circumvent the law. So we were afraid that we would force, you know, 50,000 private practices to hire another person, whose sole job is to enter orders, so that the provider doesn't have to do it.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO

And, even doing that would not get the benefit back, so there's some benefit in the efficiency and the lack of transcription errors, etc. for communicating things electronically. But from a changing practice, which affects both the quality and, in a lot of people's minds, simultaneously the cost of care. You have to get feedback at the ordering point. Some people say the pen is the most costly instrument in healthcare, and that's because of the physician orders.

Deven McGraw - Center for Democracy & Technology – Director
Right.

Latanya Sweeney – Laboratory for International Data Privacy – Director
This is Latanya. Basically it's coming down to, is this where we push back on workflow in an attempt to improve the workflow for what we think is a better quality of care issue.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
Correct. One way to do it is to say here's the reason why it really should be the best of all situations is to have an efficient way of the authorizing provider to enter orders and to receive feedback from the system. That's' the goal. And so you could say, with that in mind, you could say 100%. On the other hand, there are reasons why it may not be a good idea for any given situation, and one way to accommodate that is to set a lower threshold from your desired.

Christine Bechtel - National Partnership for Women & Families – VP
Paul, it's Christine. I just want to say, I get a little bit nervous when we start to be worried about how the workflow is going to change or not change because I think, and maybe this is naïve, but I think people are naturally incentivized to find a workflow that is efficient and going to work for them, and I'm not sure that I understand why it's bad for a nurse to get feedback at the point of care through an alert. I mean, I don't think he or she would ignore that, and the feedback would go back to the physician. But I'm just not sure that I understand the real operational difference between a nurse getting the feedback because they've ordered versus a provider.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
If you transmit, either through a verbal when you're physically present, or through the telephone, for example, an order, and a nurse later enters it in ad gets the feedback. There are a couple points. One is, not every system is programmed for the nurse to be eligible to get that feedback because they may not be an authorizing provider. And two, you've now created rework, so the nurse has to decide. You're assuming the nurse is going to pick up the phone or whatever and get back to the physician. And then what's the cost and the timeliness impact of that process.

Deven McGraw - Center for Democracy & Technology – Director
But we haven't created it. They would have created it.

Christine Bechtel - National Partnership for Women & Families – VP
Right.

Deven McGraw - Center for Democracy & Technology – Director
What I worry about with our suggestion is that we're trying to avoid the averse consequence of workflow, and we've created potentially more workflow issues by designating, but saying that it has to be the designated provider versus allowing institutions to figure out their own workflows to maximize the utility of the system and prioritizing getting this stuff in electronically, I guess, I where I'm leaning toward.

George Hripcsak - Dept. of Biomedical Informatics Columbia University – Chair
Paul, maybe this is the kind of thing that – now remember that the law actually says this. Not the law, the rule, because on the earlier page, they literally define CPOE as the authorizing provider entering the order. And then when they do the measure, they don't specify that, but they've defined, "CPOE as being done specifically by the authorizing provider." So, in some ways, this is a clarification. But if you read the rule literally, this is what they're saying.

But by separating the definition of CPOE from the definition of the measure, they make it a little bit ambiguous. And so the question is, should we just leave it alone for now and then look at stage two, what goes wrong, and do they kind of follow the spirit of the law, or do they circumvent it and then put it there in stage two? That's a question.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
Let me read from Table 2 under that first category. For eligible professionals, the objective is use CPOE, and the measure is, "Use of CPOE for orders (any type) directly entered by authorizing provider, for example MD, DO, RN, PA, NP."

Actually, I don't know. The column is not labeled. Then stage one measure says, "For EP, CPOE is used for at least 80% of all orders."

George Hripcsak - Dept. of Biomedical Informatics Columbia University – Chair
Do we need the recommendation anymore?

Deven McGraw - Center for Democracy & Technology – Director
Maybe we don't because all we did was just emphasize. You know, when it was just authorizing provider, I think people just naturally defaulted to – I don't remember questions being raised about this before until we started emphasizing that it was maybe somewhat more specific than people had originally interpreted it to be.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
Either we think it is clear, as is, or if it is open interpretation, lack of clarity actually causes more work and more angst. So we could even be contributing if we made it more clear. But if we think it is clear, as it stands, which it sounds like at least in some parts it says directly entered by the authorizing provider, then one of our comments may either be on the threshold itself, the number, because of the workflow issues, or to eliminate the requirement by direct entry. I'm not sure we'd recommend that.

Latanya Sweeney – Laboratory for International Data Privacy – Director
Paul, this is Latanya. Here's my take on what I'm hearing. I think that the overall motive to improve care, the comment that's on the table for the group to consider, would definitely improve quality, but if it were actually followed. But I think the comments, the way they're written, do have a kind of ambiguity without further enforcement that people would just use that in their workflow because what happens in a lot of these systems that require authorizing provider right now, and that don't fit into the workflow the way the provider wants, is they just give their password information to the nurse or whoever is entering it, and they still enter it the way they want to fit their workflow even though it comes up in the system as under the provider.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
Right.

Latanya Sweeney – Laboratory for International Data Privacy – Director
And so those kinds of workarounds you'd like to get rid of, but I don't think you can do it through this mechanism. I think, by pushing too hard on this mechanism, you may cause more surface resistance.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
That's fair. That is what's stated. I'll read from there the text of the NPRM. It's under the use CPOE. "We propose to define CPOE as entailing the provider's use of computer systems to directly enter medical orders, for example, medications, consultations, lab service, etc," let me move my, "from a computer or mobile device." So it's a little bit vague. "Define CPOE as entailing the provider's use of computer assistance to directly enter medical orders."

Charlene Underwood - Siemens Medical - Director, Gov. & Industry Affairs
This is Charlene. I had actually raised some of the ambiguity question because this is an issue that our customers are trying to account for CPOE use, trying to deal with. And the original words they had

recommended was licensed professionals because nurses aren't licensed to enter, for instance, medication orders. Pharmacists are, and we argued on our last call that we didn't want pharmacists to do it, but that's actually practice in many of these cases, it sounds like. So my recommendation was to use licensed professional because then you won't have the pressure. I mean, I think there's going to be pressure in the institutions to, you know, either have the nurses enter them through verbal orders or that type of thing, and that's one of the things in practice the institutions are trying to step away from. They know that's not good practice, and we could help them maybe just by clarifying it and saying licensed professionals.

George Hripcsak - Dept. of Biomedical Informatics Columbia University – Chair
There was a … I remember, I don't know who raised it, but they pointed out that in some states it doesn't have to be a licensed professional to enter an order, for example, a resident. In some states, residents are not licensed until later on in their career, so we would be eliminating them from entering orders.

Charlene Underwood - Siemens Medical - Director, Gov. & Industry Affairs
All right….

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
Actually, it was Neil that pointed it out for New York.

George Hripcsak - Dept. of Biomedical Informatics Columbia University – Chair
Yes. That may be right. I mean, it's either the end of their first year, or it might the end of their third year or something. It was Neil. Yes.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
Yes.

Charlene Underwood - Siemens Medical - Director, Gov. & Industry Affairs
It is complicated.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
One option is to stay silent on it. Another is to actually, you know, change the definition, as proposed.

Charlene Underwood - Siemens Medical - Director, Gov. & Industry Affairs
We kind of know what the intent is. The intent is exactly what you said, Paul, that the person entering the order can get the clinical decision support information back, but that's not explicitly said anyplace. I mean, it makes sense, but that intent, I think, is lost just in the line item.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
And we are reacting to that by trying to make it more explicitly and more prescriptive. I'm getting some pushback here.

Charlene Underwood - Siemens Medical - Director, Gov. & Industry Affairs
And that doesn't….

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
So we could go back to being silent on this. We will get lots of comments.

Charlene Underwood - Siemens Medical - Director, Gov. & Industry Affairs
You will.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
And they will have to be more precise in the way they define it, but it seems like we don't have a uniform wording to suggest because we see some of the flexibility that's required by the workflow and also, at the same time, recognize that the initial intent was still correct. That is, really the bang for the buck is to get the direct entry.

Latanya Sweeney – Laboratory for International Data Privacy – Director
Here's an idea. Why don't we just simply leave it, leave their wording alone, and offer alternative wording, but offer alternative, just a summary here that we suspect that they're going to get pushback on this, and remind them that the importance comes from the…. In other words, let's push it back over to them, but with some comments from us of what we figure is important.

George Hripcsak - Dept. of Biomedical Informatics Columbia University – Chair
We could state our intent, so it's not a recommendation, but an intent, which is, we're not trying to eliminate existing workflows. We're not trying to circumvent state laws. But the intent is that someone with responsibility would get the decision support, and that we don't create odd incentives to create bizarre workflows just to get around the system. It's better than saying nothing.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
Yes. It might not be much better than saying nothing. Another approach is to talk about, well, maybe along with what you just mentioned is also signal our intent that, in the future years, we should be moving towards more direct entry. We should have better systems that make it efficient to do that because CPOE does take time. So better systems and workflow that is consistent with direct entry.

Latanya Sweeney – Laboratory for International Data Privacy – Director
I like that, Paul.

Charlene Underwood - Siemens Medical - Director, Gov. & Industry Affairs
Yes, why don't you say that?

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
It's easier for you to say. George, why don't you say – you started this.

Charlene Underwood - Siemens Medical - Director, Gov. & Industry Affairs
Consistent with direct entry was very powerful.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
Okay, consistent with direct entry, so we're both looking for improvements in systems and workflow changes. Okay. That's contributory, and that also gives them a little leeway in the sense of, if we don't have it perfect, this first stage, that it can improve over time, and I think that also is responsive to the industry feedback as well. People happy with that?

Deven McGraw - Center for Democracy & Technology – Director
Yes.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
George, are you going to help?

George Hripcsak - Dept. of Biomedical Informatics Columbia University – Chair
Yes, I should write that first half that I just said.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
And then I can write the second half.

George Hripcsak - Dept. of Biomedical Informatics Columbia University – Chair
…write the second half, yes.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
Great. Okay. The final comments are on page 7/8, has to do with our famous recommendation 12, and where we came down just by votes, and some were closer than others, is illustrated in this table. So we've broke the 3/1/1, and now it's 3/0/1/1/0, and I think the table probably is the easiest way to look at

that. In the first category, because it has the most number of measures, there are three that you are able to defer, but there are mandatory, which includes the demographics, including the race, ethnicity, and language. The use of CPOE, and the use of eRx, the conduct of eRx, those are all pretty much in statute. That seems reasonable, both on the mandatory and then the number we picked is three, so there's not much change there.

The second one was changed to having no deferrals on the engaged patients and families section. The third, we took out the possibility of mandatory in the care coordination, so there's one deferral allowed. In population health, there was one deferral allowed, and there never was any deferral allowed in the privacy and security.

Deven McGraw - Center for Democracy & Technology – Director
I wonder, Paul, since we took some votes on these, and some of them were closer than others, whether it is fair or makes sense to note those, which were closer calls, as opposed to being, you know, in the past, our recommendations out of the policy committee have been, we haven't taken votes on them, and they've been concensus based.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
Right.

Deven McGraw - Center for Democracy & Technology – Director
And in this case, you know, we took votes, and we raised our hands, and we were, in a public forum, accountable for weighing in on one side or the other, and some of them were close.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
Right.

Deven McGraw - Center for Democracy & Technology – Director
Without designating necessarily who voted for what because anybody who was there could have seen it, I think I'm putting out there that I think it's fair to note those for which there was a fair amount of disagreement among policy members, committee members.

Christine Bechtel - National Partnership for Women & Families – VP
Yes. It's Christine. I think that's fair too.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
Okay, so just lift it? So I'll tell you which they were. Care coordination, it was seven to five in favor of the no mandatory. In public health, it was seven to six, and I also think there might have been a little bit of voting discretion involved here, but seven to six.

Deven McGraw - Center for Democracy & Technology – Director
An extra person? Maybe somebody abstained from that other vote.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
No, actually, I don't think the timing of raising the hands was necessarily consistent.

Deven McGraw - Center for Democracy & Technology – Director
Okay.

George Hripcsak - Dept. of Biomedical Informatics Columbia University – Chair
That's what we have, so that's all right.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
That's what we have, yes.

Charlene Underwood - Siemens Medical - Director, Gov. & Industry Affairs

On the public health one, I think there's going to be a lot of individual comment back, so I'm not sure. I think CMS is going to have to look. So for instance, like the reporting labs out of a hospital system, oftentimes those are done in a different way, so I think you're going to get some specific line item reporting back on some of these items that CMS has to consider. Immunization registries, are they everywhere, all those types of things. I think you're going to get that discretionary type of input back. The main call that we see coming back is, we want to do this, but if you could just standardize the way we do it and reduce the variability, that would really help us, you know.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
Yes. I think….

Charlene Underwood - Siemens Medical - Director, Gov. & Industry Affairs
So if you're going to get a lot of individual items because of the local dimensions in that particular public health one.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
Was somebody else trying to say something? Okay. So the revision to this was to indicate the closeness of the vote.

George Hripcsak - Dept. of Biomedical Informatics Columbia University – Chair
Paul, just for consistency, we should also delete the security objective.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
That's true. I don't know why that's there.

George Hripcsak - Dept. of Biomedical Informatics Columbia University – Chair
Yes. It's just like we don't have them listed for engage … yes, so we should not have it. That's just out mistake. And then will people ask questions about the quality measures?

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
Actually, that's one of my extra topics, so let me – let's talk about that when we get…. Are we finished with this letter, as it stands?

Charlene Underwood - Siemens Medical - Director, Gov. & Industry Affairs
Do we have the one on the recommendation in terms of transitions of care here?

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
Yes, we do. We defined….

Charlene Underwood - Siemens Medical - Director, Gov. & Industry Affairs
Again, this is when I was doing some other follow-up. There was still concern relative to was it – it's clear on the hospital side and the ambulatory side. It was still a bit tricky in that, you know, when you know when you go to a doctor and you come back for the next visit, that type of thing. That's not considered a transition of care, but if you go to a specialist, it is, so we didn't link it to referrals. So it was still causing confusion, I think, as you look at the dimensions on the ambulatory side.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
Okay. To accommodate that particular scenario, would it help to include the referral link?

Charlene Underwood - Siemens Medical - Director, Gov. & Industry Affairs
The recommendation, and this actually was that I got back on this one was provide summary care for each transition of care or referral to make it more – and they actually looked at measurable. Provide a summary of care record, and they did it upon request. I see, to make it something you could count, but I don't think that's going to move us forward either.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO

I don't think that will either.

Charlene Underwood - Siemens Medical - Director, Gov. & Industry Affairs
So that didn't help me.

Micky Tripathi - Massachusetts eHealth Collaborative - President & CEO
I think it's fair that if you are….

Charlene Underwood - Siemens Medical - Director, Gov. & Industry Affairs
Is the intent? You're not? Like every time you go see your doctor, your intension is, is that when you want one?

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
Well, it's every time you make – you go from one setting to another.

Charlene Underwood - Siemens Medical - Director, Gov. & Industry Affairs
That seems to make sense to me. I was pretty clear on that, but they were confused.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
Well, let's tease out, do you have an idea why they were confused?

Charlene Underwood - Siemens Medical - Director, Gov. & Industry Affairs
I think it was more, there are two issues: one, if you're within an integrated continuum, you need to do that, right?

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
The answer is yes. That's what the intent is.

Charlene Underwood - Siemens Medical - Director, Gov. & Industry Affairs
All right. That was, but if it's in the same database, so … Kaiser and that type of thing, and it's all there, right? So do you really need to do that?

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
Well, but the exercise is to – there are two exercises. One is just medical practice, and you should. And the other is for the EHR to have the functionality that facilitates that med rec.

Charlene Underwood - Siemens Medical - Director, Gov. & Industry Affairs
I know we're trying not to be prescriptive.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
Right. And also—

Charlene Underwood - Siemens Medical - Director, Gov. & Industry Affairs
That's where it was getting confusing is, you start with an integrated system and, again, you'll refer to a specialist, but the data is in the database, so you don't really need to issue that.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
But we don't know that the patient is still taking. So George and I will tell you that this does not happen, and this does cause errors. And so one of the things we want to try to do is to make it easy for us to, including the patient, easy for us to reconcile meds, particularly as we go from setting-to-setting. So the patient has a role too, and they can do that through their PRH, for example. But it's not the state of the practice for us to do this med rec when that would be good for the patient.

Charlene Underwood - Siemens Medical - Director, Gov. & Industry Affairs
Okay. I think we just have to leave it because that's the standard. I think we'll get some clarification in the comments back on that probably.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
Right. Other comments on that particular issue since that is one of our recommendations? Okay. Are we done with this letter then, as it exists? The two other topics, one is on thresholds. We have set, so let me recount where we came from. When we put virtually all of these objectives and criteria together, we talked about, in year one, stage one, that we were interested in reporting on these measures, and we did not set any thresholds.

And I think part of that is that, one, we don't actually know where we're starting from, the baseline, so it's hard to say how far we can push. Another is that we imagine that, over time, 2013, 2015, that the concept of a threshold would be introduced and potentially increased over time. That's how I recall our discussions and intent when we first developed the concept of both reporting and phasing. Is that consistent with other people's recollection?

Latanya Sweeney – Laboratory for International Data Privacy – Director
Yes.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
Okay. What did get changed in the NPRM is to set thresholds, and I think they're rather high, so they're mostly 80% and some 50% when there's exchange of data. One consequence is that, all of a sudden, the measure and its definition becomes important because it's 80%, which is high, and then what happens at 78%, which is part of how we got into the flexibility discussion.

On the one hand, so there are two. One of the insights I had, as I started thinking about this, one is whether you set it at 80%, or let me just pick a random number of 50%. If you, in good faith, are trying to accomplish something, you're not going to say, oh, we're at 51%. Let's stop all progress. No more new users have to go do this. That's senseless. You would do as much as you can because you've already started both the functionality and the workflow changes. In a sense, some threshold, some reasonably threshold would already get the good that we're trying to get out of it.

Now on the other side, on the measurement side, to quality, we're all aware that there are limitations to measurement, both limitations in the way you measure, as well as the cost and burden of measuring. And so CPOE is one example. The problem list is another. There are lots of these costs.

Now you can substitute for the actual thing you're trying to measure, which may actually require manual observations or chart review, for something that is a surrogate or an approximation of what you're trying … the true measure. And yes, that surrogate probably has a different denominator, maybe lower numbers or whatever, the same thing about the numerator, but it is a low cost. It pops out of the EHR. I'm just describing a hypothetical. Something with a low burden that approximates the true thing you're trying to measure.

Now if the threshold was a lot lower, not your real goal. Your real goal may be 100% or 95% or whatever it is. But in the surrogate measure, you might live with something much lower because you understand that the measure is limited in its reliability, accuracy, etc. But taking rationale number one, which is, once you get past some threshold, say 50%, then you probably are doing something on the good side. And we don't want the limitation of the measure to cause undo burden and undo angst about the way it's defined. That's an additional rationale behind what we originally were proposing, which is no measure, just reporting only, so open for your reactions in terms of, one, are thresholds good? Two, high thresholds, what are the positives and negatives of high thresholds?

Charlene Underwood - Siemens Medical - Director, Gov. & Industry Affairs
This is Charlene on that one. Because we're just starting, it would seem, and I don't know if it's a threshold or not, some base measure, if you could get one, with all those criteria around it would be a great starting point, and I don't know if there could be a few of them rather than a bunch of them. I don't think this should be a reporting exercise in what we're doing. I think it should be an implementation

exercise to get started, so I'm going to bias towards that. But you need to at least measure some part of the process to get a sense of, are you going the right direction or not.

Latanya Sweeney – Laboratory for International Data Privacy – Director
This is Latanya. I think that I really take to heart the comment you made that once I make a commitment to something, the actual number that comes out of the percentages is not the issue. The issue is, did I make the effort, or did I synchronize my workflow and make sure the machine had the capability.

One way to kind of think about that though is if we had a way of approximating what is the workflow commitment. What the 80% and the 50% do is they say, well, you have to – they give a level of effort that's required by the provider to think in terms of his workflow and the kinds of changes that are needed to try to achieve the 80%. What would be horrible is if he made those changes, and then he came in at 75%. So I'm not sure exactly how to reconcile it, but the 80% and the 50% definitely related to, if I were the provider, as to how much effort and change I'm willing to make in my procedure. I mean, my workflow. I shouldn't use procedure.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
The bottom line on your suggestion then, Latanya, is, would you keep a threshold and just set it lower? One way to interpret what you said is, 80% and 50% are a way of signaling where to put your effort. Its intent, I think, was if you could do it on your own, meaning not depending on exchange networks, etc., then they set it at 80%. And if you relied on other people, they set it at 50%. That's what I read as their rationale for those two numbers. And so what are you saying by the 80% and 50%?

Latanya Sweeney – Laboratory for International Data Privacy – Director
And I think that that's somewhat correct. What bothers me about it is that I go through it. I realize that, in my practice, I have a certain situation where I know I'm not going to be able to do this, but I'm willing to make these changes, so I can make sure that I can hit what I think will be the 80%. Then some number comes out at the end, and it's 75%. I think that would be horrible.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
Yes.

Latanya Sweeney – Laboratory for International Data Privacy – Director
And I think, in the absence of having either measurements that are the base that we can go by, or workflow analysis that we could look at, we don't have either of those. We're kind of stuck, and I'm not sure how to get around that. I mean, I think the intent, I think everybody is aligned on the same intent, but I just don't know. I'm a little worried about putting a hard number in, and I guess all of this discussion that I just entered in didn't take us anywhere. Sorry.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
Well, our original approach was to report without thresholds would be consistent, is one view that would be consistent with what you just said. And I think what Charlene said too because you basically both said, gosh. I don't know how hard that's going to be, for one, and that's the whole lack of baseline. And, two, I also don't want to – somebody with good intent, getting 75% when 80% is the number. That could talk about a quantitative that's the level. Christine, George, Deven?

Deven McGraw - Center for Democracy & Technology – Director
Yes. I mean, I'm struggling with that too. I mean, I even tried to massage in my head a couple of days ago, was there some way to sort of try to set some levels based on how everyone collectively performs, and then require everyone to be above the median, but then that was….

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
Banged by the curve.

Deven McGraw - Center for Democracy & Technology – Director

Way, way, way too … so it didn't go anywhere. But what about bands, 60% to 80%, you know, that if you have tried and you end up falling short, and you're between 60% and 80%, you should get paid.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
Why 60%, 80%? Why not…?

Deven McGraw - Center for Democracy & Technology – Director
I don't know. I made that up.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
No, but I'm saying, why? What does a band do more than a threshold?

Deven McGraw - Center for Democracy & Technology – Director
It gives a range. So in other words, you're shooting for something, but if you're a little bit short, and I confess that I haven't quantified what a little bit would be, and hence I came up with a 20 percentage point range, but I just, you know, just sort of struggling to set goals, but also give people some leeway to try and miss.

Christine Bechtel - National Partnership for Women & Families – VP
Yes. It's Christine. I've been having the same struggle in my mind. I first also thought of a grade on a curve approach, and realized that from an operational perspective that's pretty tough. But then thought about what if you said, you know, that the threshold is 80% or whatever the threshold is, but that as a rule, that a provider who achieves, you know, within a certain percentage of that threshold would still be paid because, and I don't think that's – there's no approach that's perfect—let me just say that—because the downside of that approach is, well, then why wouldn't you just lower the threshold and require meeting or exceeding that, but then I think you get into the same argument. If you lower the threshold to 50%, and 20%, let's say, somebody who hits 49% is still going to be a problem.

I think the one middle ground, well, the middle grounds are probably either report the percent, and some guidance that it ought to be approaching 80% or whatever the case might be, but knowing that just reporting, which is sort of what we did in quality measures where we want you to report the percent of your patients with an HbA1c under control, but we're not requiring that 80% of your patients actually have an HbA1c under control. So I see the value in that approach, Paul, which is the one that you outlined. My concern is that it's significantly – it's a very significant step down from where we're at. But also, I'm worried that where we're at is a little bit too high.

Again, I'm going to use Latanya's phrase. I don't know that everything I've just said has added anything. But I did at least think of an approach where if you're within 20% of meeting the threshold, you're still going to get credit because, I partial payment was an option here, I would say that's where we need to go, but it's not an option.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
Let me try to summarize the three comments, the sentiments behind.

George Hripcsak - Dept. of Biomedical Informatics Columbia University – Chair
Paul, I would say the problem is, they want to keep it simple. So to keep it simple, and to me, 10 is like 20, and 50 is like 80, so if it's just making it 50% instead of 80%, I'd be fine with that because it means you really did it, whereas 10% or 20% means you really didn't do it, like order entry. So order entry, 10% or 20% means you didn't do it, but 50%, you essentially did it. I mean, I don't know what you didn't do, but you certainly were in the spirit of the law. So I see 50% is a lot like 80%. My band is a little wider, I guess. And then I think we have to keep it simple because they're not going to want to do a more – they were already worried about the idea of….

Deven McGraw - Center for Democracy & Technology – Director
George, you cut out.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
You cut out.

George Hripcsak - Dept. of Biomedical Informatics Columbia University – Chair
I cut out? Can you hear me?

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
Yes, now we can.

George Hripcsak - Dept. of Biomedical Informatics Columbia University – Chair
I walked across the room. They were worried about the complication of implementing our deferrals, never mind, you know, anything. I think they have to just have a threshold, whatever it is. And whether 80% is too high, and 50% is right, but you're right. There'll always be someone who just missed that, and that's why they have 80%. As far as they're concerned, the threshold is 100%, and the 80% takes care of the people who only made it to 98%. That was their logic, more or less, right?

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
Yes.

George Hripcsak - Dept. of Biomedical Informatics Columbia University – Chair
But I would … to 50%, personally.

Charlene Underwood - Siemens Medical - Director, Gov. & Industry Affairs
Yes. This is Charlene, and I just wanted to share. There was a call the other day I was on. I think Neil was on it. I know he's not on our call, but in that case, it was a physician who was automating e-prescribing. Again, because of gaps in people don't want e-prescription. You can't send it, etc. Their best case, working really hard, was 44%. That's why this measurement space, I think that if there was a way to accept anything, my recommendation was, give us – I'd like us to move toward vetted measures, and let them report anything, and they should get credit on it, so we know where they're at, and not give a threshold would be my preference in phase one.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
Let me try to summarize the two major concepts in this discussion, and then see if those are the things we're actually trying to either decide or vote on. One, I think the unanimous sentiment that 80% is too high for a number of reasons, everything from the limitation of the measurement to the extenuating local circumstances. That's theme one. Am I right about that one?

Latanya Sweeney – Laboratory for International Data Privacy – Director
Yes, from what I heard.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
Yes. Okay. The second concept is whether there should be a number or a reporting, and I didn't hear unanimity about that, but that is the second issue that we're dealing with. Is that right?

Latanya Sweeney – Laboratory for International Data Privacy – Director
I think everyone is in favor of reporting. The question is, should there be a threshold.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
Right.

Latanya Sweeney – Laboratory for International Data Privacy – Director
And if so, what should it be.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
In some people's mind, there is no threshold. It's reporting only. And in some people's mind, it's a lower number, but it is a number. I think we're united in the, it should be lower than 80% because it probably, in

our minds, when you take into account all the things that can legitimately decrease you, compromise your ability to reach 100%, it's probably lower than 80%. Now let's talk a little bit further about should it be just reporting, or should it have a threshold?

Latanya Sweeney – Laboratory for International Data Privacy – Director
This is Latanya. You know, there's some nice advantages to just reporting and then using that to make a curve to decide what the next year's numbers should look like.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
Yes, just a baseline. It's not only a baseline. It's part of understanding whether you have the right definition, which almost certainly we don't, starting out today.

Latanya Sweeney – Laboratory for International Data Privacy – Director
You know what we could do, Paul? Here's an idea. I'll throw it out. Feel free to shoot it down. What we could do is say, the first year you report, we're going to try to get you by 2015 to 80% or 90% or whatever, and that we're expecting a percentage increase from where you report to there to come out to the 80% by 2015.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
That was our original intent, actually, so that was the original strategy.

Latanya Sweeney – Laboratory for International Data Privacy – Director
That's probably why I remember it. No, but I meant, actually say it that way. Let them report whatever the number is. So if I report, and I came in at 10%, now I know I've got to put a lot of effort to get to the 80% by 2015. I'm letting them know that now.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
That's right. Be more explicit about the expectation.

Latanya Sweeney – Laboratory for International Data Privacy – Director
Right.

George Hripcsak - Dept. of Biomedical Informatics Columbia University – Chair
Can you report a zero?

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
Yes. That was one of the things we actually, I think we literally almost said those words for some of these things.

Deven McGraw - Center for Democracy & Technology – Director
Yes.

George Hripcsak - Dept. of Biomedical Informatics Columbia University – Chair
Can you report all zeros? Can you be zero across the board?

Deven McGraw - Center for Democracy & Technology – Director
Yes.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
As long as you want that on your Web page, that's fine.

George Hripcsak - Dept. of Biomedical Informatics Columbia University – Chair
Well, but that means you get, I mean, but what do you have to do then?

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
I see what you're saying. I'm sorry.

George Hripcsak - Dept. of Biomedical Informatics Columbia University – Chair
You may not have to install a system if you need zero….

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
I'm sorry. Yes.

Charlene Underwood - Siemens Medical - Director, Gov. & Industry Affairs
That's actually my same issue—this is Christine—with just reporting is that you could report one percent or 3% or 10% across the board, and basically have just decided in the last month to buy a system and deploy it or whatever. It just feels like you could have somebody who is really at a super beginning stage, and I think it raises questions of what is that going to mean for, by 2015, doing things. If we reduce the requirement, I would agree with, I think, what's the core of Latanya's question, which is to define the end state first, and to say, by 2015, we expect that you're going to be doing all of this, and more, at the 80% threshold across the board, barring maybe a few exceptions on data exchange.

But as I think about some of the core requirements that we have in here, like recording demographic data as structured data, if we start to see that providers across the country have 5% of their patients in the electronic system, and they've got the rest on paper so that they can get federal funding, I don't think that's Congress' intent, so I'm struggling with the report issue because I think you can just have people report….

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
No, that's very fair, and in fact, I think this argument has swayed my view as well. It sounds like it may have swayed Latanya's … other one spoke in favor of just reporting. Is that true, Latanya?

Latanya Sweeney – Laboratory for International Data Privacy – Director
Yes, it is. Now how do you know that? I must have two microphones on.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
Yes.

Latanya Sweeney – Laboratory for International Data Privacy – Director
Data privacy issue.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
I can summarize what you were going to say too.

Latanya Sweeney – Laboratory for International Data Privacy – Director
Okay. In other words, you're psychic.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
Okay. So let me try to state our latest incarnation of this. So we believe that the threshold is an important element of this initiative, this HIT adoption for meaningful use initiative. That it would be almost certainly a high threshold in the later years, such as 2015, but that we believe that it should be considerably lower in 2011. And we could leave that up to their discretion, but explain why we think that. Is that consistent with people's views?

Josh Seidman – ONC
Paul, this is Josh. I just want to raise that in just looking at something that was brought up at the policy committee, I think it would be important to discuss a process for getting this.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
Yes, I'm going to.

Christine Bechtel - National Partnership for Women & Families – VP

One other way to think about this would just be to suggest that CMS reduce, that all 80% thresholds should become 50%. All 50% should become 30%, but that the 10% or the one time test would remain.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
Let me speak first to the numbers. I think we could, if we wanted to propose numbers, we should do the work to make the numbers as best we can. I don't think that's what we're doing right now.

Christine Bechtel - National Partnership for Women & Families – VP
Yes, I feel better about that, Paul, because I think there are some things like structured demographic data that should probably be at a higher threshold. Are you suggesting that we would go through at some point and say this specific threshold becomes this threshold?

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
But we absolutely don't have time to do that for stage one, so I think what I heard in the discussion today is that we think that it should be a significantly lower number than 80%, but non-zero.

Christine Bechtel - National Partnership for Women & Families – VP
Right.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
And that that's something that CMS, we're asking CMS to take that into account. We could, as part of the letter, just indicate our own willingness to work on the numbers for the future years and provide recommendations for those, but I don't see how we could possibly give numbers for 2011 and do it justice.

Deven McGraw - Center for Democracy & Technology – Director
I think that's right. I think that the general conversation is likely the most that we can do because ideally we'd want to get policy committee endorsement even on that because otherwise it's just us.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
Right, right.

Charlene Underwood - Siemens Medical - Director, Gov. & Industry Affairs
Paul, this is Charlene. In terms of the numbers and the thresholds, I mean, NQF has a process that you can get a vetted measure out of. I mean, can't we recommend that they should do this work, so we get vetted threshold numbers out of that process? They have an HIT utilization committee.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
Yes, but does it provide thresholds?

Charlene Underwood - Siemens Medical - Director, Gov. & Industry Affairs
Yes, it does. I mean, if you want percentage of physician orders, they can figure that out for you.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
That's an interesting thought.

Charlene Underwood - Siemens Medical - Director, Gov. & Industry Affairs
And if you get the NQF endorsed measure, then everyone lines up.

Deven McGraw - Center for Democracy & Technology – Director
Yes, but except not all of these are endorsed measures. Not all of the meaningful use measures are NQF endorsed measures.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
Right.

Charlene Underwood - Siemens Medical - Director, Gov. & Industry Affairs
But if you're saying in year one, you know, we can go there is all I'm suggesting, because then we'll get out of these debates, and you're going to have, like to calculate these measures, you're going to get apples and oranges, right? So I think that we want to vet a set of measures that you'd define, you know, collectively or however they, you know, whatever that standards process is.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
Are you talking about 2011 or future years?

Charlene Underwood - Siemens Medical - Director, Gov. & Industry Affairs
Well, I'm saying at least whatever the recommendation should say that, as we're moving forward, to establish these measures. They should be vetted.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
Yes.

Charlene Underwood - Siemens Medical - Director, Gov. & Industry Affairs
Like you said, we don't have time to work on them, right?

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
Right.

Charlene Underwood - Siemens Medical - Director, Gov. & Industry Affairs
And there's a process in place to work on them, and I think they should work on them.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
That's a good suggestion. Let me try to recap again. For 2011, our suggestion is that, our recommendation is that the threshold be lowered significantly from the current 80%/50%, that it be non-zero, and that we would undertake the extra work or, per Charlene's recommendation, find someone who can set appropriate threshold numbers for the out years, for the 2013 and 2015 years. Is that correct?

George Hripcsak - Dept. of Biomedical Informatics Columbia University – Chair
I'm sorry, Paul. Say that again.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
Okay. So that our recommendation for 2011 is that the threshold numbers be significantly lowered for reasons that we will enumerate, and that we will undertake to identify a process, whether it's concensus among ourselves or looking at external entities, to put out numeric thresholds that are considered through some appropriate means. You know, what should be the threshold for demographics? What should be the threshold for problem lists? What should be the threshold for CPOE? There has to be an individual, case-by-case assessment if you're going to put a number out there, and we can signal our willingness to identify a process for coming up with those numbers.

Is there a problem? Do I need to split them up into two different things?

George Hripcsak - Dept. of Biomedical Informatics Columbia University – Chair
Yes, I'm okay with the first one.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
Okay, so let's go with the first one first. The first one is that we believe that the thresholds that have been used in the 80% and 50% thresholds that have been specified in the NPRM should be significantly lowered, but non-zero.

George Hripcsak - Dept. of Biomedical Informatics Columbia University – Chair
Yes.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
All in favor of that?

Latanya Sweeney – Laboratory for International Data Privacy – Director
I am.

George Hripcsak - Dept. of Biomedical Informatics Columbia University – Chair
Yes.

Latanya Sweeney – Laboratory for International Data Privacy – Director
Yes. This is Latanya.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
Okay.

Christine Bechtel - National Partnership for Women & Families – VP
I think that's good, Paul. But I think, going back to a technique we used earlier, we ought to be pretty clear about what our intent is here, because I think there are some things like, again, demographic data or whatever, where 50% or 60% is probably fine. So I think we just have to signal how we think about things.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
Yes. We'll put the same rationale, both about the – you know what, people who are, in good faith, doing something, they're not going to stop at a number. So you just have to have some credible number for them. And then we recognize the limitations of the measurement, both the measurement definition itself, as well as the local constraint. So that kind of thing, but our intent is that, over time, people move up to the maximum, which may be very close to 80%.

Latanya Sweeney – Laboratory for International Data Privacy – Director
Right, but Christine is also saying something else. She's saying that – don't mean to put words in her mouth, but what I heard was her say that not all the uses are the same. Some of the uses, you should….

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
Okay. We'll say that too. Okay. Got it.

Christine Bechtel - National Partnership for Women & Families – VP
…too, so it's kind of a good train going here.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
Yes. Okay. So now that's part one, and I think I heard unanimity about that.

Latanya Sweeney – Laboratory for International Data Privacy – Director
Yes.

Christine Bechtel - National Partnership for Women & Families – VP
Yes.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
Part two is whether we commit to undertaking a way to come up with numbers, threshold numbers, for future year measures. And that doesn't necessarily mean doing it ourselves, as Charlene pointed out. It could be NQF.

Latanya Sweeney – Laboratory for International Data Privacy – Director
This is Latanya. I mean, unless there's a huge agenda coming down the road, I think it's a great idea because it's very informative. But, I mean, I wouldn't want to put 80% of our effort in that direction.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
Right.

Christine Bechtel - National Partnership for Women & Families – VP
I'd support something that I think Latanya raised earlier, which was that that work about thresholds should also be based in out years on how the field is doing and….

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
That's true. Okay. That's actually a really good thought, so sensitive to the ongoing evaluation of how things….

Christine Bechtel - National Partnership for Women & Families – VP
Right, and it doesn't mean that people just sort of aren't doing, you know, they're not doing that much in that area, so the threshold should be low. I think it's about understanding, you know, why. Are there really barriers, or is it a resource … issue?

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
Right.

Christine Bechtel - National Partnership for Women & Families – VP
It's a little more complex, but that's the right, general thing.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
Right. Good point.

Latanya Sweeney – Laboratory for International Data Privacy – Director
And, ultimately, it's kind of our feedback back to us as to where the issues might be.

Christine Bechtel - National Partnership for Women & Families – VP
Yes.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
Okay. So we are in favor of threshold numbers. We are in favor of finding, identifying some process to come up with reasonable ones, and it should include not only our baseline, but an assessment, an ongoing assessment of how well the field is doing, how well people are doing in the field. Did I capture that correctly?

Charlene Underwood - Siemens Medical - Director, Gov. & Industry Affairs
That's excellent.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
Do people agree with that one?

Christine Bechtel - National Partnership for Women & Families – VP
Yes.

Deven McGraw - Center for Democracy & Technology – Director
Yes.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
Okay. George, I didn't hear your voice.

George Hripcsak - Dept. of Biomedical Informatics Columbia University – Chair
I guess my question is, the goal is 100% eventually.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO

Yes.

George Hripcsak - Dept. of Biomedical Informatics Columbia University – Chair
So is … tweaking them if we're a little bit further behind now, that'll stay at 50% a little longer, as opposed to kind of implying that, well, you know, whatever, well, progress notes aren't on there, but CPOE. I mean, all of them are going to end up near 100% hopefully, right?

Latanya Sweeney – Laboratory for International Data Privacy – Director
Right.

Charlene Underwood - Siemens Medical - Director, Gov. & Industry Affairs
This is Charlene. To some extent, I think there may be some market pressure to have, like they said, do you want to report zero, you know.

George Hripcsak - Dept. of Biomedical Informatics Columbia University – Chair
Right.

Charlene Underwood - Siemens Medical - Director, Gov. & Industry Affairs
There's going to be some pressure to get those numbers up just because you're reporting them.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
We don't know exactly how that'll work. I mean, for all we know….

Charlene Underwood - Siemens Medical - Director, Gov. & Industry Affairs
I mean, I think Paul is right. I think we don't know a lot, and the more we can just start to move that process forward and learn from it, I think that's going to help us adjust.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
I think we had all votes except for George. George, are you going to vote? You're on mute. Hello, George? Maybe his cell phone cut out.

Let me describe now, and I'll answer Josh's question, which is, yes. This is – we have discussed this topic, but we did not make a recommendation in our draft letter and in front of the committee. We would need to have a committee vote on this if they want us … letter. The proposal would be to call a conference call, hopefully a brief conference call, of the committee in time to get this letter to CMS in a timely way.

We originally committed to March 1st, and so did all the rest of the working groups that are working on recommendations in parallel. We've been granted a reprieve of a few days, so that I think it's by the end of the week that we get it in to CMS. It does give us some time, very little time, but it does give us time to call a quick phone meeting of the committee in order to have them approve or reject this.

Latanya Sweeney – Laboratory for International Data Privacy – Director
Paul, in my e-mail today, I got a notification … March 3rd.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
March 3rd?

Judy Sparrow – Office of the National Coordinator – Executive Director
I sent it out, Paul, just giving people a heads up.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
What time?

Judy Sparrow – Office of the National Coordinator – Executive Director
It was the time you and I talked about. Was it 10:00 to 11:00 eastern, I think, on March 3rd. Was that right, Latanya?

Latanya Sweeney – Laboratory for International Data Privacy – Director
I'm looking it up right now.

Judy Sparrow – Office of the National Coordinator – Executive Director
Yes. Anyway, a couple people will be at HIMSS. Off the top of my head, I think, Borland, Neil Calman, and there was one other person. But I was thinking maybe you could get those votes in writing, perhaps, and then have a voice vote on anybody that joins the call.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
Okay.

Latanya Sweeney – Laboratory for International Data Privacy – Director
The time is 10:00 to 11:00.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
Okay. So that's 7:00 to 8:00 my time.

George Hripcsak - Dept. of Biomedical Informatics Columbia University – Chair
Hello, Paul. Sorry. I don't know what happened.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
We're waiting for your vote.

George Hripcsak - Dept. of Biomedical Informatics Columbia University – Chair
My vote was no because I'm afraid of the delay, but it brings uncertainty into the process that people don't know ahead of time what the threshold is going to be, and who is really going to be deciding the threshold, and that's my worry. It brings more uncertainty and delay into the whole process.

Deven McGraw - Center for Democracy & Technology – Director
We're talking about later stages, George.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
Yes.

George Hripcsak - Dept. of Biomedical Informatics Columbia University – Chair
Sorry. We're going to do 80% to 50% for stage one.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
No, no, we're talking about lowering the 80% and 50% in stage one to some non-zero number.

George Hripcsak - Dept. of Biomedical Informatics Columbia University – Chair
Yes, yes, 80% down, 50% down for stage one, and then set … thresholds later on.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
Correct.

George Hripcsak - Dept. of Biomedical Informatics Columbia University – Chair
Okay. Then I'm okay. Yes. I vote yes.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
I don't know about you guys. I'm in only a six-story building, but our building is shaking in the wind.

Deven McGraw - Center for Democracy & Technology – Director
Are you sure it's the wind? You're in California.

Christine Bechtel - National Partnership for Women & Families – VP
Where are you at, Paul?

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
Oh, is that it? Well, if you don't hear from me, it's not because I'm on mute.

Deven McGraw - Center for Democracy & Technology – Director
That's terrible.

Charlene Underwood - Siemens Medical - Director, Gov. & Industry Affairs
That's scary.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
No, it is truly windy out here. Good. So we will have a call of the full committee about this. Now the second topic may also be included in this committee vote, but is on quality measures. Once again, we talked about this, and we talked about it in public and in the full committee about quality measures and the importance of them, and this moment of opportunity to get "good quality measures". So not only in the statute did the statute call for, in my interpretation, good quality measures, when it said clinical quality measures, unlike the billing quality measures we have now. And we, through our principles and the framework, said that we wanted to pick a few that were already known to be good, and use them as exemplars to exercise the whole system.

What we got back in the NPRM is a lot of measures, again mostly on the administrative and claims, using administrative and claims data, and a lot of measures that aren't even in PQRI and…. We've certainly heard comments about that, but I guess I'm more concerned about the missed opportunity to start moving the quality measure in the direction that makes more sense to clinicians and makes quality and public reporting more sensible. I'm concerned that we did not turn that into a recommendation.

Now, on the one hand, probably CMS is – and I'm not talking from direct knowledge, but probably one of the things that's going into their mind is what can they do with today's systems. You already know that 2011 is attestation. 2012, they're hoping to have electronic receptions. So probably the stage one capabilities of their systems that incorporate new measures is limited, and we can certainly understand that. But wondered if we could include some language that signals that our intent always was that we would have new measures, not rely on old measures, that would derive from bills, new measures derived from EHRs that would more clearly reflect the clinical quality and talk about that as our deliberate goal for 2013 and 2015.

Charlene Underwood - Siemens Medical - Director, Gov. & Industry Affairs
Paul, this is Charlene. We've done – we're doing the analysis, the vendor community, and I'm sure a lot of others, but to go through each of the measures and try and figure out, does it have spec, does it not have a spec. But here's the good news. A lot of them, because of the direction you've been setting. I know this is personal. Are architected in the longer term to move to SNOMED, as well as to ICD-9 in the interim, and I'd rather not move to ICD-9. I'd rather just jump right to something else rather than have to do it twice. So there is good news.

The less positive news is that, you know, kind of exactly what you said, like on the hospital side. They introduced. They asked HITSP to kind of retool measures that hospitals don't even report today, so there's a whole rack of those news out there, which doesn't make any sense because you don't have any two-fors.

There's more possibilities, I think, to get something done on the eligible professional side, but I don't know, and I can't tell you right this minute without looking at the spec if it's going to meet your criteria of

being one of those great measures. There are three diabetes ones, and one coronary artery disease one, but I don't know if it's spec'd in the way that you want it to be.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
Yes. It doesn't change the suggestion. You're just saying that some of them are helpful.

Charlene Underwood - Siemens Medical - Director, Gov. & Industry Affairs
Yes.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
But in general, I don't think we have the measures we need to do the kinds of transformation that we're looking for, and we're hoping just this, you know, an initiative like this would produce. Other people's feelings?

Christine Bechtel - National Partnership for Women & Families – VP
Paul, I think I need you to restate. You're basically saying we should characterize exemplar measures and say this is where we need to go for 2013 and 2015, but I'm not sure how. I'm not understanding what you're talking about would impact 2011.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
I'm probably saying not. I'm trying to signal that we understand how current systems may limit the kinds of measures that people are being asked to report on and that can be received. But clearly the way to take advantage of this system, to implement electronic health records and capture clinical data should be to report on credible measures that reflect the clinical data. So that means developing new measures, and that's another reason why you can't have them in 2011. Developing new measures that truly reflect the clinical quality that's delivered using clinical data from an EHR, and that that would be something that ONC and CMS need to think about funding the measure developer. So there are implications of that, but m proposal is that we signal that we think that that would be an important direction for the program to go in 2013 and 2015.

Christine Bechtel - National Partnership for Women & Families – VP
Yes. I completely agree with that. I think we talked about that a fair amount, so I think that's right.

David Lansky – Pacific Business Group on Health – President & CEO
Paul, it's David. I'm sorry I joined late, but I also strongly agree with doing that. I'm not sure. Are you thinking of doing that as sort of closing comments in the letter, or is it a separate means of communication?

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
Closing comment in the letter. I don't know whether you were here, David, when we said what we're going to have to do is get a committee vote on the changes we made anyway, so introducing this won't change anything.

David Lansky – Pacific Business Group on Health – President & CEO
Right. Particularly as we discussed in the letter … core measures and so on, we sort of signaled that the work done for 2011 wasn't adequate to our objectives, and it seems like it would be natural, especially if we could figure out very quickly what the three or four principles we want to suggest for future development, what they are. That is, what do we mean by a good measure? And that would give a signal to ONC, CMS, NQF, or whomever that by 2013, we're going to be really looking for X, Y, and Z in terms of characteristics of those measures.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
Right.

David Lansky – Pacific Business Group on Health – President & CEO
If we could figure out those bullet points, that would be worth – I definitely think that's worth doing.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
Thank you.

Christine Bechtel - National Partnership for Women & Families – VP
Paul, it's Christine again. I think it would make sense under recommendation two where we talk about the criteria we use to assess … core measures.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
Good.

Christine Bechtel - National Partnership for Women & Families – VP
Just to add it into the narrative there would be fine, and not at all, I think, a change to what we're saying.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
The only difference – man, I'm being pretty unnerved by the building here, but the only thing I would – the reason I would make it recommendation 13 is because it is such a major thrust that to bury it under another concept might not do it justice.

Christine Bechtel - National Partnership for Women & Families – VP
Yes. I get that. That makes sense.

George Hripcsak - Dept. of Biomedical Informatics Columbia University – Chair
I agree with that.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
Okay. Let me take a vote here on that recommendation. It would be a recommendation, so one, understanding how the current system limitations and current available measures may limit what we can measure, but making it a deliberate intent to focus on clinical quality measures that are defined using data from an EHR in the 2013, in stage two and stage three. And that ONC and CMS undertake the necessary steps needed to produce those measures. All in favor?

Deven McGraw - Center for Democracy & Technology – Director
Aye.

David Lansky – Pacific Business Group on Health – President & CEO
This is David. Yes.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
Any opposed? Okay. So anyone help in submitting bullets are useful, so we'll have to get the language around these things out, and certainly incorporate it over the weekend, so that we can put it in front of the committee before the call on the 3rd so that they can approve or reject parts of these new elements.

Charlene Underwood - Siemens Medical - Director, Gov. & Industry Affairs
Yes. Paul, the question I have to raise then is this part about what do we do in 2011. I mean, at the end of the day, what it says, what the NPRM says is that of those 43 hospital measures and equal number of eligible professional members, they will be able to generate those from their EHRs and plug them into whatever system, and they're asking us to comment on it. Should it be 2011 or 2012? But at the end of the day, for lots of different reasons, there might be four of them we might be able to do on the EP side because we have a spec or, you know, or it's not a lot of the work in the workflow, or it doesn't require abstraction and all those kinds of reasons. And maybe that number on the hospital, if that, but even on the hospital side, the testing hasn't even started. Like at least on the ambulatory side, they've been testing submission of measures. We're just signing up for that first round of testing, so we have no clue if we can capture what they want in the workflow, no validated clue yet.

What do we, like, there's a reality here, and do we want, I mean, there's going to be a rasp of comments that comes in on this, guaranteed, because the states either were silent and say the future needs to be this, but actually our recommendation kind of in the near term is we should start with measures they're reporting today. Look at those that are most eligible, if you will, to be computed electronically, and begin that testing process. Don't start with brand new ones. Start with those they're using today. It reduces burden. Then create a transition plan and a glide plan so that we move down this path.

Then as the committee starts to formulate better and newer measures, we've got that testing process out of the way, so there are a few of them that ask for it at discharge. Okay. We can probably get that. There are a couple of them that, again, it's going to require an additional function in there that's perhaps doable, but at least we get that testing, and we get that infrastructure process going in the near term so that when you define your new measures, you know, that piece is done.

Christine Bechtel - National Partnership for Women & Families – VP
Can I ask a couple questions? This is Christine. Charlene, when you say we can get that measure when you're talking about kind of reporting measures that hospitals are already reporting under programs like … do you still mean reporting electronically, or do you mean just crediting the report that they submit under the way they do it under…?

Charlene Underwood - Siemens Medical - Director, Gov. & Industry Affairs
We could do that. I mean, we can talk through that.

Christine Bechtel - National Partnership for Women & Families – VP
I think that's a really important point because what I think the value of meaningful use is, is not to just add another. You know, you've got to report it for this program, so you've got to report it for this one over here in the exact same way. That's not the value here. The value here is really what kinds of measures can actually be reported directly from an EHR, and ideally is a byproduct of providing care. Otherwise, what's the difference between it in…?

Charlene Underwood - Siemens Medical - Director, Gov. & Industry Affairs
Yes. We're totally aligned with, and that piece is unclear, the one you just went. If we could, rather than reporting, a pneumonia measure, or I prescribed aspirin, it's a really easy one. Through … and today they extract it and then they enter it. If we could automatically derive that and submit that directly, not have to report it twice, that would be nice. That's the direction that this recommendation would be in the near term is, of those measures they report today, choose one or two, and take them through that testing methodology. So CMS's infrastructure is ready. Right? We figured out on the front end how to work with them, right, so we can report those measures in stage one, so that when stage two comes, and more measures start to be derived, that piloting and testing process is in place.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
Is it your suggestion to substitute for reporting, to do this test? I'm not sure I get what you're saying, what you're recommending.

Christine Bechtel - National Partnership for Women & Families – VP
Before you answer, Charlene, let me ask my other question. I thought that, and maybe I've confused myself because we have talked about it a lot, and I've read the rule too many times. I thought that the quality measure reporting right now in stage one is attestation, which was precisely so we could figure out the testing to do the electronic report, unless they can also report through something through a PQRI type registry.

Charlene Underwood - Siemens Medical - Director, Gov. & Industry Affairs
In 2011, what it says, you know, if you look at those cross estimates, derive those measures, it assumes that they're a byproduct of capturing the data from the EHR. They're not captured in current methodology. So it makes the assumption in the rule that to be able to capture, and I can give you, you know, one of these examples, and I could just tell you. A lot of these, you can't do today because there's not a spec or it requires a lot of rework. There's an expectation that they can be derived from the EHR.

And then you'll just enter them into whatever reporting mechanisms CMS wants. That's the expectation, as we read it in the rule today.

Christine Bechtel - National Partnership for Women & Families – VP
Your focus is on this data capture through the EHR, because reporting right now is summary data by attestation.

Charlene Underwood - Siemens Medical - Director, Gov. & Industry Affairs
Yes, regardless of how they collect it, which is mostly manual and sampling today. So the recommendation is, and should be fewer numbers, but the recommendation is to kind of follow along what Paul was saying is that there should be a selection of a subset of, a small set of those numbers, you know, to begin the direct reporting with in stage one. And, in 2011, we should go through the testing process of those few measures, and then, you know, as soon as CMS is ready, start to do the actual direct reporting from the EHR into whatever the reporting infrastructure is, which they're working on.

Christine Bechtel - National Partnership for Women & Families – VP
How is that inconsistent with what is already in the rule because CMS has said, they're not requiring reporting of all those … they want a subset, and they're looking for comments on which ones are appropriate.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
Yes, I'm mixed up too.

Christine Bechtel - National Partnership for Women & Families – VP
What you're describing sounds like what's in the rule.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
You might even – it sounds like you even want them to go beyond that and do the testing.

Charlene Underwood - Siemens Medical - Director, Gov. & Industry Affairs
Well, actually we do.

Christine Bechtel - National Partnership for Women & Families – VP
Yes. I think they will be doing … because they have to be able to accept data, quality data electronically in out years, so they are going to do the testing, but that for purposes of 2011 and, hence, this comment letter, I'm not sure how what you're suggesting is different.

Charlene Underwood - Siemens Medical - Director, Gov. & Industry Affairs
There's like 43 measures there. Are you just saying your interpretation is there's no expectation those 43 have to be reported on?

Christine Bechtel - National Partnership for Women & Families – VP
Right, that CMS said, and Tony Trenkle told us on a workgroup call a couple months ago that they proposed more measures than they knew that they would pick. That they would choose a subset, but they were asking for input on what the subset is. Now how big the subset is, I don't know. He didn't say.

Charlene Underwood - Siemens Medical - Director, Gov. & Industry Affairs
Okay. And I'm usually on your calls. I just might have missed that, but that, I don't think, is the interpretation in the industry.

Christine Bechtel - National Partnership for Women & Families – VP
I think it's written in the rule, but I'd have to go back and look.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
Yes. They actually set some numbers for the EPs, but not for the hospital. They said they're looking for three to five for each of the specialty tables. They did not make a similar number for the hospital, but I

thought that that was their intent is to put a bunch of measures out there and see which ones make sense, and so expecting your comments really.

Charlene Underwood - Siemens Medical - Director, Gov. & Industry Affairs
Then we should applaud them for that, and also just, with the goal of reinforcing. What I would like to see is … reinforce. It should be measures that they report today as opposed to starting with some brand new measures, but we'll say that. So the same policies that you're talking about in terms of reporting, the other measures should also apply then.

Micky Tripathi - Massachusetts eHealth Collaborative - President & CEO
Wasn't another issue that—this is Micky—that it's easier to take things away from a rule or not do things in a rule, but harder to add things?

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
Yes. Well, actually, they can't add things.

Micky Tripathi - Massachusetts eHealth Collaborative - President & CEO
Right, so they're trying to create some kind of framework that's broad enough that you can interpret it a number of ways….

Christine Bechtel - National Partnership for Women & Families – VP
Yes, exactly. They put out a big list because they can't put stuff in retrospectively, and so they're looking for comment on what the smaller list should really be. I mean, you know, as we at the National Partnership have done, our comment letter, it does provide some criteria that we think they should use in choosing those, that subset of measures, although since we're not a hospital, we're not going into the detail of which measure and whatnot.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
Okay. Charlene, I think probably you may have had some clarification on what is being asked and what's being welcomed. And I think you're providing input that really address, I mean, is fulfilling what they've requested actually.

Charlene Underwood - Siemens Medical - Director, Gov. & Industry Affairs
Yes.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
Okay. Any other business?

Latanya Sweeney – Laboratory for International Data Privacy – Director
Paul, this is Latanya. I could use some guidance, especially, I'm glad David is on the phone, about sort of two new meaningful uses that sort of have popped up over the last week. You can tell me if this is something not here, offline, wait until next year, whatever. But I really could just use some advice.

The two uses is the one that came up yesterday in the safety hearing about online reporting of bug and safety reports. And the second one is a realization, and David can speak to this. We don't have a meaningful use that requires connectivity of the machine to support communication of exchange information over the Internet. Assuming or what's likely to happen, the NHIN working group is going to have some recommendations that are going to come through the pipeline, but the basis, some of the people may have purchased, may not necessarily have the infrastructure to use it.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
With regard to the first, I certainly took those notes as well that I think we can't do anything about 2011.

Deven McGraw - Center for Democracy & Technology – Director
This is Deven. Is this related to the FDA Sentinel Initiative?

Latanya Sweeney – Laboratory for International Data Privacy – Director
The first one is….

Deven McGraw - Center for Democracy & Technology – Director
For postmarket surveillance of drugs and devices?

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
Yes. We weren't specifically linking it to their existing program, but we did talk about post marketing surveillance as part of the FDA's testimony, and we certainly talked a lot about a model similar to the patient safety organizations where there is a way to report EHR safety concerns. One of the suggestions was that it be easy to capture the context so that providers, busy providers, can easily capture, here's where the situation arose, and I can write down either a note now or later, and at least make it easy to report because that's the biggest barrier.

Deven McGraw - Center for Democracy & Technology – Director
Right.

Latanya Sweeney – Laboratory for International Data Privacy – Director
Right, and so one idea they came up with is if I was online, and I saw the wrong patient's information was mixed with my current patient or any of the examples that they gave. I could push a button, and it would capture the screen image or something like that. I'm … manufacturer, but it would be able to produce a bug report or a safety report that could then be forwarded to someone internally.

What I'm worried about is we need a way for manufacturers to know that that's in the pipeline. We also need a way for the public to know.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
Yes. I think it's not possible for us to introduce a completely new concept in our 2011, but in the report out and the recommendations that come from the workgroup that met yesterday, that certainly can come, and that will be, that can be a good signal to the industry.

Latanya Sweeney – Laboratory for International Data Privacy – Director
But do you think that will happen? I'll have to take your lead on that. I'm just worried.

Deven McGraw - Center for Democracy & Technology – Director
Yes. There was a whole lot of stuff that came up on some of our privacy calls. It's like, oh, this would be great to have in the first round, and that basically, I think, any new stuff is not possible, given the … procedure….

Latanya Sweeney – Laboratory for International Data Privacy – Director
The timetable…. So what about the connectivity problem?

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
I don't know. Well, certainly, we have not prevented it, and I would guess most people have it, are connected for lots of reasons. So I'm not sure it is a major hole in the sense of, in practice, we'll just be missing. But we certainly didn't explicitly have it, no.

Christine Bechtel - National Partnership for Women & Families – VP
But I do think, Latanya, this is Christine, as I think about the recommendations that need to come out of that hearing, I think they're also much broader than just meaningful use, that there may be some things that are appropriate for MU. But on the other hand, there's so much more for even parts of the federal government that ONC, you know, outside of ONC, and I think we have to remember at ONC is the Office of the National Coordinator, so there's … role in coordinating with other federal agencies besides HHS that would be very important here. And so I think that set of recommendations will be broad, and should be.

Latanya Sweeney – Laboratory for International Data Privacy – Director
Right, and that working group is working on those, but this particular issue, to give them a heads up, so the manufacturers use the meaningful use criteria to convert that to engineering specifications. And once the unit is purchased, 2013 and 2015 have to be add-ons, not replacements. They don't want all out replacements, but have to be incremental add-ons and updates to what they've put in place. And so they have to be signaled, certain kinds of core infrastructure have to be in the machine.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
I think the way this would flow out….

Latanya Sweeney – Laboratory for International Data Privacy – Director
Let me just say one thing. And so, the online reporting of bug and safety reports, Paul Egerman had actually asked. I talked to him afterwards, and he sort of said it also in the meeting to you, Paul. That's something for the meaningful use group to think about.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
Right. We will. It's just not 2011.

Latanya Sweeney – Laboratory for International Data Privacy – Director
Okay.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
It's beyond, I mean, the horse is out. The way, as far as the Internet, I think that's clearly going to come up through NHIN, and will end up getting incorporated into the certification criteria, as the way I think that, you know, that's the flow that seems to make sense.

Latanya Sweeney – Laboratory for International Data Privacy – Director
I like that actually, but we just need a way to signal it because I don't think there' a letter coming from the NHIN working group.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
They are, well, David is the one that can address that, but they'll certainly have recommendations. They've already had some.

Latanya Sweeney – Laboratory for International Data Privacy – Director
Right, but those aren't recommendations that are going to CMS. Those are recommendations to the policy committee.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
Correct.

Latanya Sweeney – Laboratory for International Data Privacy – Director
Right, but we need a mechanism that goes outside. So Epic is at the table. Cerner is usually in the room. But others aren't, and so they use the meaningful use as the way that they do their engineering specification. So if there's no commentary coming out, they – it's perfectly reasonable to have a machine that doesn't talk on the Internet, and it be certified based on meaningful use.

Charlene Underwood - Siemens Medical - Director, Gov. & Industry Affairs
Just to add one additional point from the vendor association view, which represents the majority … this is a very important topic, and I endorse that, but this has been a pretty broad topic across our whole membership. We had a vote on it. I think Michael Stearns was there yesterday representing that viewpoint to just kind of say this has been a topic across the industry to build the awareness of the need. So I think there may be, if there are recommendations that can come back sooner, I think there are other pathways to get those through, meaningful use being one of those. But again, this has pretty high visibility in the industry now and has had in our membership, so it's broader than just Epic and Cerner.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
Yes. I think we've already created the meaningful use objective, which is through the care coordination, as an example. And another example is really the availability to patients the patient information, so that's got to come through the Internet. I think the meaningful use substrate is there, and the way that it would get further refined and defined would be through … through the NHIN that works its way through the certification.

David Lansky – Pacific Business Group on Health – President & CEO
I was going to make one other comment. I think that the NHIN workgroup … responded to the meaningful use criteria … said okay. Whatever comes out of 2011…. Whatever came out of 2011 criteria from the meaningful use would guide the specifications for the first phase of NHIN requirements, and so we have a little bit of a cart and horse problem that we should try to sort out. Part of … last conversation makes me wonder is whether we, the meaningful use committee … here's the baseline … subset of previews of 2013 that would give people a chance to debate the scope and depth of what we're proposing … connectivity…. Are we going to be able to, somewhere in the next six months or so, describe what we think the connectivity requirements will be for 2013? That goes beyond the fairly limited ones we've proposed for 2011.

Latanya Sweeney – Laboratory for International Data Privacy – Director
Yes, because, I mean … you might think in terms of the Internet being the default, but a lot of them are modem-to-modem communications.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
This might be something we take up at a different call other than dealing with this letter, so I can better understand what, David, you think is needed from the meaningful use workgroup to support the NHIN work.

David Lansky – Pacific Business Group on Health – President & CEO
Yes. I think we could do it some other time. But I guess the … what's our schedule this year, and when do you think – when have you been advised that everybody wants to hear from us as a firs pass at the 2013, either conceptually or in detail proposal.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
I haven't heard. Are you talking about for meaningful use or for NHIN?

David Lansky – Pacific Business Group on Health – President & CEO
Yes, meaningful use.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
I've gotten mixed messages. We have to listen to our own recommendation that says we want to signal as much as possible the industry and the providers about what's coming down the pike. So I think we probably want to get on that and, you know, some folks thought we should be opining on this as early as the middle of this year, and others are later. So I think it's in the latter half of this year that we should be starting to talk more about it.

We're going to get back on track, and that's a good thing to bring up at this call that we're going to get back on track in our serious of hearings to talk about the different categories. The next step was patient and family engagement. We're finishing up that series, and then I think we'll have some more reaction. We'll have the final rule out, etc., and start working on 2013 and 2015. Does that make sense?

David Lansky – Pacific Business Group on Health – President & CEO
Yes. I'm just thinking back to Latanya's point. It may be worth having a hearing or some vehicle this spring for discussing, broadly speaking, the connectivity/Internet question, how much of meaningful use is interaction among providers and with families and patients.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO

Maybe there's some kind of joint thing with at least part of the part of the members with NHIN and meaningful use?

David Lansky – Pacific Business Group on Health – President & CEO
Yes, and the HIE group that Micky is working with.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
Then maybe it's actually abutting our full committee, like we've done in the past.

Deven McGraw - Center for Democracy & Technology – Director
But we had some issues come up in our privacy and security workgroup too, more with respect to certification components that might be missing from the original set. That would be critical for exchange, especially if much of it might occur by e-mail, like no secure e-mail standard.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
My goodness.

David Lansky – Pacific Business Group on Health – President & CEO
Yes, it's kind of a can of worms because then it opens up….

Latanya Sweeney – Laboratory for International Data Privacy – Director
Yes, it is a can of worms.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
That's a can of worms.

David Lansky – Pacific Business Group on Health – President & CEO
…question too.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
More of a Pandora.

Latanya Sweeney – Laboratory for International Data Privacy – Director
I was just trying to only get the manufacturers to get an alert that they should think in terms of Internet and not modem-to-modem, which is, there are a lot of them out there who are on modem-to-modem. And so then if you bring in Internet, and so providers provide those machines. In 2013, the NHIN specifications are on the Internet, it's going to be an issue.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
I'm thinking it's not going to be easy for people to give electronic access to patients without involving the Internet.

Latanya Sweeney – Laboratory for International Data Privacy – Director
No, but electronic access to patients without involving the Internet is a slightly different issue. They might have a Web portal. If it's a hospital, the hospital might offer a Web portal and give a passport to the patient who can go download it using a Web browser and so forth.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
I know, but how are they going to get the information to their server?

Latanya Sweeney – Laboratory for International Data Privacy – Director
That can go through their own Intranet, right? That doesn't have anything to do with the Internet. Do you see what I mean?

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
I'm not seeing how you could outright avoid the Internet.

Latanya Sweeney – Laboratory for International Data Privacy – Director
I could be in my own organization. If I'm a small provider, I might just simply have two machines and copy a file from one machine to the other where the other one has the Web server, so there are lots of ways I can solve the patient problem without my machine, in terms of its normal exchange, involving the Internet. And so since exchange is in meaningful use, and they build those exchanges to use modem-to-modem communication, what happens when you come into 2013, and NHIN kicks in? It's going to be totally different. Everything is different. I'm not using the modem to do my exchange. I'm going to use the Internet. I've got to change not only my software requirement, but my hardware requirement.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
I can see how you can get into that situation. I can see that it seems to me that you'd have to work at it to put yourself in that box.

Latanya Sweeney – Laboratory for International Data Privacy – Director
No, the reason the hospital systems like that box is because they don't have to solve computer security problems. If I have the computers on the Internet, then I have to make sure certain security protocols are kept up and so forth. If I say no, this machine is not going to be on the Internet, but you're going to communicate with the labs, you're going to communicate … we're going to do this all by modems. Then … secure communications, sort of security through obscurity, which creates, of course, a lack of interoperability.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
Yes. Okay. I wanted to save some time for the public. Anything more about the letter or topics that we've discussed? We'll try to get you a revision. I don't know how, but we'll try to get you a revision over the weekend, any other fine-tuning before we get it out to the rest of the committee. Any other comments procedurally, Josh or Judy?

Judy Sparrow – Office of the National Coordinator – Executive Director
No, I think if maybe just ask if the public are there and want to make a comment. Josh, do you have anything? No, we're okay here. Operator, do you want to check with the public?

Operator
There are no questions.

Judy Sparrow – Office of the National Coordinator – Executive Director
Great.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
Thank you, everyone. Thanks for making the time. Thanks for a good discussion, and we'll try to get you some revised documents out soon.

Judy Sparrow – Office of the National Coordinator – Executive Director
Great. Thank you, Paul.

David Lansky – Pacific Business Group on Health – President & CEO
Thank you, Paul.

Latanya Sweeney – Laboratory for International Data Privacy – Director
Thanks a lot, Paul.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
Bye-bye.

George Hripcsak - Dept. of Biomedical Informatics Columbia University – Chair
Bye.